STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN46818

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/06/11 and 09/07/11 Facility Number: 000255 Provider Number: 155364 AIM Number: 100273280 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Byron Health Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This four story facility with a basement was determined to be of	K0000	This Plan of Correction will serve as the written allegation of compliance. Preparation and / or execution of the plan of correction does not constitute admission or agreement by Byron Health Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared as a provision of federal and state regulations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridors. The facility has a capacity of 191 and had a census of 123 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/13/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 1 corridor doors to the second floor weight room, 19 of 21 corridor doors in Section 1 and 9 of 10 corridor doors in Section 3 north were equipped with positive latching hardware. This deficient practice could affect any resident near the second floor weight room and any resident evacuated through the Section 1 hall or Section 3 north halls in the event of an emergency. Findings include: a. Based on an observation with the Director of Plant Operations on 09/06/11 at 2:00 p.m., the corridor door to the second floor	K0018	A. DOOR LATCH ON 2ND FLOOR WEIGHT ROOM DOOR (OCCUPIED RESIDENT AREA)1. Door Latch on the 2nd Floor Weight Room Door will be replaced with a latch that latches into the door frame.2. In the case of a fire, any resident in the vicinity of the weight room could have been affected by this practice. All other door latches in resident occupied areas were inspected and found to adhere to code.3. Door latches will be inspected by maintenance staff as part of routine facility inspections. Door latches found to be defective will be replaced.4. Facility issues will be reported to the facility wide QA committee on a quarterly basis.5. Date of Completion is 10/7/2011.B. CORRIDOR ROOMS OF UNOCCUPIED SECTIONS 1 & 3Sections 1 & 3 are currently vacant units and are unlicensed with the state. The	10/14/2011

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	weight room had roller latching hardware. This was acknowledged by the Director of Plant Operations at the time of observation. b. Based on observations with the Director of Plant Operations on 09/06/11 at 2:40 p.m., nineteen corridor doors in the Section 1 hall had roller latching hardware and on 09/07/11 at 10:45 a.m., nine corridor doors in the Section 3 north had roller hatching hardware instead of positive latching as required. Emergency exit signs identified each of these halls as emergency egress corridors. Based on an interview with the Director of Plant Operations at the time of observations, the Section 1 hall and Section 3 north hall are currently closed and used for emergency exit only. 3.19-(b)		units are not used in any type of resident care. These units are closed and locked and not open to any passing traffic. One Exit sign will be removed from Closed Section 1 and two Exit signs will be removed from Closed Section 3. "Not an Exit" signs will be fastened to the old exit Section 1 double doors. "Not an Exit" signs will be fastened to old exit Section 3 double doors.There are 8 alternate Egress means for areas close to section 1. (OPS Northstair, Southstair, EastStair, West Ramp, Section 11 Northstair, Section 12 South, Section 12 North, and Section 12 East).There are 5 alternate egress means for areas close to section 3. (Northstair, Southstair, Eaststair, West Ramp and Section 11 North). Maintenance staff will monitor the new signs as part of routine inspections to insure that the signs are hanging properly and in full view. Any issues will be reported to the facility wide QA Committee on a quarterly basis.Date of Completion is 10-14-2011.	
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation, interview and previous measurements; the facility failed to ensure 2 of 18 corridors were maintained to provide adequate headroom. LSC	K0038	1. While cited as deficient, no residents have been affected by this deficient practice.2. Residents are not required to use the corriders cited as deficient. No resident living	10/07/2011

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	7.1.5 requires the means of egress shall be designed and maintained to provide adequate headroom as provided in other sections of this Code and shall not be less than 7 ft 6 in. with projections from the ceiling not less than 6 ft. 8 inches nominal height above the finished floor. The minimum ceiling height shall be maintained for not less than two thirds of the ceiling area of any room or space, provided the ceiling height of remaining ceiling area is not less than 6 ft. 8 in. This deficient practice could affect any residents, staff and visitors in the facility who would use these basement corridors. Findings include: Based on observations on 09/06/11 from 11:45 a.m. to 3:15 p.m. and on 09/07/11 from 9:45 a.m. to 1:15 p.m. with the Director of Plant Operations, the following areas in the basement failed to provide adequate headroom: a. The basement ceiling height in the east-west corridor measured six feet two and one half inches. Additionally, there was a pipe protruding below the ceiling along		areas, activities, or services are conducted in areas requiring residents to access ths corider.3. Waiver has been issued by the state for many years and will be continued. (See State Form 54147 - Life Safety Code Waiver Request).4. No monitoring required, but resident incidents are reported to facility wide QA Committee on a quarterly basis.5. No systemic changes were made and no completion date is needed.	

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	the 70 foot corridor that measured five feet seven inches from the floor. Based on interview with the Director of Plant Operations at the time of observations, the measurements from the previous survey on 09/01/10 were used and are accurate. b. The ceiling height at the south basement corridor smoke barrier wall measured five feet nine inches. Additionally, there was a pipe protruding below the ceiling which ran along the center basement corridor that measured six feet from the floor and the north-south corridor intersection had pipes protruding below the ceiling which ran along the corridor that measure five feet nine inches from the floor. Based on an interview with the Director of Plant Operations at the time of observations, the measurements from the previous survey on 09/01/10 were used and are accurate. 3.1-19(b)			

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K0056 SS=E	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 1. Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler heads in the small conference room closet and 2 of 11 sprinkler heads in the third floors nurses' station area were separated by at least six feet as required by NFPA 13. NFPA 13, Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect any resident near the third floor nurses' station and any staff in the small conference room in the event of an emergency. Findings include: a. Based on an observation with the Director of Plant Operations on 09/06/11 at 12:23 p.m., the small	K0056	A. Small Conference Room Closet1. Closet was originally designed with a wood panel down the center of the closet which divided the closet into two units. A sprinkler head was installed in both sides of the closet. The wood panel was removed in later years creating one open closet. One of the sprinkler heads will be removed so that the area will meet code.2. Any resident or staff in the small conference room could have been affected by this deficient practice; however, no incidents have occurred.3. Sprinkler heads will be checked during routine maintenance rounds and any defects will be corrected.4. Facility Issues will be reported to the facility wide QA committee on a quarterly basis.5. Date of Completion is 10/7/2011.B. Third floor nurses Station1. One sprinkler head will be moved so as to be incompliance with code at no	11/07/2011

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	conference room closet had two sprinkler heads located less than six feet apart. b. Based on an observation with the Director of Plant Operations on 09/06/11 at 12:32 p.m., the third floor nurses' station area had two sprinkler heads located less than six feet apart near the # 2 elevator. This was acknowledged by the Director of Plant Operations at the time of observations. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 1 of 1 kitchen loading dock areas in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice was not in a resident care area but could affect any number of kitchen staff. Findings include: Based on an observation with the		closer than six feet on center.2. Any resident, staff or visitor near the third floor nurses station could have been affected by this deficit practice; however, no incidents have occurred.3. Sprinkler heads will be checked during routine maintenance rounds and any defects will be corrected.4. Facility Issues will be reported to the facility wide QA committee on a quarterly basis.5. Date of Completion is 10/7/2011.C. Kitchen Loading Dock1. The kitchen loading dock will have one extended coverage dry side-wall sprinkler head installed by our sprinkler system vendor.2. Any kitchen staff in the loading dock vicinity during a fire could have been affected by this deficient practice; however, no incidents have occurred.3. Once the sprinkler head as been installed, deficit situation will be rectified.4. The sprinkler head will be monitored along with the entire fire suppression system through quarterly inspections by the vendor.5. Date of Completion. Sprinkler head will be installed and operational prior to 11-05-11.	

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	Director of Plant Operations on 09/07/11 at 10:20 a.m., the enclosed loading dock in the back of the kitchen which was separated from the outside with a garage door lacked sprinkler coverage. Based on an interview with the Director of Plant Operations at the time of observation, he confirmed the loading dock did not have a sprinkler head. 3.1-19(b)			
K0062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to replace 1 of 5 sprinkler heads in the second floor shower room which was loaded (dirty). LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection,	K0062	1. The sprinkler head near the 2nd floor shower room that had a build up of grime on it has been replaced. 2. Any staff, residents, or visitors near the 2nd floor shower room during a fire could have been affected; however, no incidents have occurred.3. All sprinkler heads in occcupied resident areas will be set up on a cleaning schedule within the Housekeeping Department to	10/07/2011

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	Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect all residents in or near the second floor shower room. Findings include: Based on observation with the Director of Plant Operations on 09/06/11 at 1:15 p.m., there was a buildup of grime on the sprinkler head near the door in the second floor shower room. Based on an interview with the Director of Plant Operations at the time of observation, when asked what was on the sprinkler head he stated grime that could be removed when scraped off with his fingernail. 3.1-19(b)		eliminate this deficient practice from happening in the future.4. Director of Environmental Services will report to the facility wide QA Committee of the schedule and progress of the cleaning schedule quarterly.5. Date of Completion 10/7/11	

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K0070 SS=D	Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation and interview, the facility failed to have a policy for the use of 1 of 1 portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient practice is not in a resident care area but could affect any staff in the Quality of Life office. Findings include: Based on observation with the Director of Plant Operations on 09/06/11 at 2:18 p.m., there was a space heater in the Quality of Life office. Based on an interview with the Director of Plant Operations at the time of observation, the facility does not allow space heaters. 3.1-19(b)	K0070	1. The employee was verbally counciled about the dangers of a space heater in the facility and the space heater was removed from the premises. 2. No residents, employees, or visitors were adversely affect by this deficient practice.3. The maintenance department staff will be watchful for any space heaters within the facility. If space heaters are found in the facility, they will be confiscated or the employee will be asked to remove the space heater immediately.4. Any issues involving space heaters will be reported to the facility wide QA committee on a quarterly basis.5. Date of Completion 10/7/11	10/07/2011

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K0071 SS=F	Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 Based on observation and interview, the facility failed to ensure 1 of 1 laundry chutes was provided with a fire rated door assembly that is self closing. LSC 9.5 requires compliance with LSC 8.2. LSC 8.2.3.2.1(b) requires fire doors shall be self closing. This deficient practice could affect all occupants. Findings include:	K0071	1. The laundry chute doors in the soiled utility room on each of the facility's three floors have been made operational and meet code by latching into the door frame.2. No residents or staff were found to have been adversely affected by this practice.3. Laundry chute doors will be inspected by maintenance staff as part of routine facility inspections. Any laundry chute doors found to be out of coded will be repaired as soon as possible.4. Any facility issue will	10/07/2011

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	Based on observation with the Director of Plant Operations on 09/06/11 from 12:50 p.m. to 2:31 p.m., the laundry chute was located in a soiled utility room on each of the first, second and third floors. The laundry chute door in each soiled utility room lacked latching hardware and failed to latch into the door frame on all three floors. This was acknowledged by the Director of Plant Operations at the time of observation. 3-19(b)		be reported to the facility wide QA committee on a quarterly basis.5. Date of completion 10/7/11	